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Prudential
Bring Your Challenges

DOL issues final rules on disability claims procedures

Employee benefit plans that are subject to ERISA must follow certain benefit claims and appeals procedures. In November 2015, the Department of Labor (DOL) proposed changes to the disability claims procedure rules that mirrored those applicable to group health plans under the Affordable Care Act. In December 2016, the DOL issued final rules that generally adopt the proposed rules with a few modifications.

The final rules apply to claims for disability benefits in retirement plans, which may include nonqualified "top hat" plans. However, they do *not* apply when a plan conditions the finding of a disability to be made by a party other than the plan for purposes other than making a benefit determination under the plan. *For example, if the retirement plan document provides that pension benefits shall be paid to a person who has been determined to be disabled by the Social Security Administration or under the employer's long-term disability plan, the ERISA disability claims procedures do not apply to the retirement plan.*

These rules are effective January 18, 2017, and apply to claims for disability benefits filed on or after January 1, 2018.

Independent and impartial review

The final rules require that plans providing disability benefits must ensure that all claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Therefore, decisions regarding hiring, compensation, termination, promotion, or similar matters with respect to any individual must not be made based upon the likelihood that the individual will support the denial of disability benefits.

For example, a plan cannot provide bonuses based on the number of denials made by a claims adjudicator. Also, a plan cannot contract with a medical expert based on the expert's reputation for outcomes in contested cases, rather than the expert's professional qualifications.

Disclosure requirements

The final rules require the following information be included in both initial denial letters and appeal denial letters:

- The basis for disagreeing with any disability determination by the SSA or other third party disability payer, or any views of health care professionals or vocational professionals treating a claimant, regardless of whether the information was relied upon;
- If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgement for the determination, or a statement that such an explanation will be free of charge upon request;
- Internal rules, guidelines, protocols, standards or other similar criteria of the plan that were relied upon in denying the claim; and
- A statement that the claimant is entitled to receive, upon request, relevant documents.

The final rules also add a new disclosure requirement for appeal denial letters. In addition to notifying claimants about their right to bring civil action under ERISA, the letter must describe any contractual limitation period for a lawsuit and the expiration date for that limitation period. In the preamble, the DOL also clarified that the limitation period may not expire before the conclusion of the plan's internal appeals process.

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These disclosures must be provided in a culturally and linguistically appropriate manner. Therefore, if a claimant's address is in a county where at least 10% of the individuals in that population are literate only in the same non-English language (as determined by the United States Census Bureau), the notices must include a statement in that language about the availability of language services. In addition, plans must provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language and provide written notices in that language upon request.

Right to review and respond to new information before final decision

Under the final rules, a disability plan must provide the claimant the right to review and respond to any new or additional evidence or rationale obtained by the plan during pendency of appeal. This information must be provided to the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan, insurer, or other person making the benefit determination in connection with the claim. This evidence must be provided as soon as possible and sufficiently in advance of the plan's decision on appeal to give the claimant a reasonable opportunity to respond. The DOL has indicated that this requirement is not satisfied by providing a notice to the claimants informing them that such information is available upon request.

Deemed exhaustion of claims appeal process

The final rules provide that if a plan fails to adhere to all the claims procedure rules, the claimant would be deemed to have exhausted administrative remedies and may pursue court action, unless a limited exception applies. The exception applies when the violation was:

- De minimis;
- Non-prejudicial;
- Attributable to good cause or matters beyond the plan's control;
- In the context of on-going good-faith exchange of information; and
- Not reflective of a pattern or practice of non-compliance.

Coverage rescission

The claims procedures apply to any adverse benefit determination. The final rules amended the definition of adverse benefit determination to include a rescission of disability benefit coverage (cancellation or discontinuance) having retroactive effect, unless it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Next steps

Plan sponsors should review the information in this publication to determine potential impacts to their plans. Sponsors of individually designed plans and nonqualified "top hat" plans should check to see whether their plan document conditions disability benefits on a determination made by a party other than the plan and, if not, whether such a provision should be adopted. When the determination of a disability is not made by a party other than the plan, sponsors should review this issue with legal counsel and, as necessary, take steps to update their plan documents and claims procedures accordingly, e.g., needed plan amendments, updated summary plan description/summary of material modifications, updated administrative practices, etc.

Sponsors of plans that use Prudential's document services will be contacted by Prudential if any changes to plan documents are necessary for these updated procedures.